KNOWLEDGE AND ATTITUDE TOWARDS MENTAL ILLNESS AMONG TEACHERS IN THE SELECTED SCHOOLS IN SIVAGANGAI DISTRICT, TAMILNADU

MS. Gnanaguruvammal .G

A DISSERTATION SUBMITTED TO TAMILNADU Dr. M.G.R MEDICAL UNIVERSITY, CHENNAI, IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE DEGREE OF MASTER OF SCIENCE IN NURSING

MARCH – 2010

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Name :Ms. Gnanaguruvammal.G

Registration No : 30085443

College Name :Matha College of Nursing
Vaanpuram,Manamadurai
Sivagangai.(Dt) TN.

Batch :2008 -2010 (March 2010)

Submitted to : The Tamilnadu Dr.M.G.R.Medical University, Chennai

MATHA COLLEGE OF NURSING

(Affiliated to TN Dr.M.G.R. Medical University),

VANPURAM, MANAMADURAI-630606, SIVAGANGAI DISTRICT, TAMILNADU.

CERTIFICATE

This is the bonafide work of **Ms. Gnanaguruvammal.G** M. Sc., Nursing (2008 -2010 Batch) II year student from Matha College of Nursing (Matha Memorial Educational Trust) Manamadurai – 630606. Submitted in partial fulfillment for the Degree of Master of Science in Nursing Affiliated to the Tamilnadu Dr. M.G.R. Medical University Chennai.

Signature: _____

Prof. (Mrs). Jebamani Augustine., M.Sc., (N).,

Principal

Matha College of Nursing

Manamaduari – 630606

College Seal:

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***Approved by the dissertation Committee on*: _____**

Prof. (Mrs). Jebamani Augustine., M.Sc., (N),

Principle cum Head of the Department,

Medical Surgical Nursing,

Matha College of Nursing, Manamadurai.

Guide: _____

Prof. (Mrs). Thamaraiselvi,

Professor In Nursing,

Matha College of Nursing, Manamadurai.

Medical expert: _____

Dr. S.Ganesh Kumar, M.B.B.S, D.P.M.,

Consultant psychiatrist,

M.S. Chellamuthu Trust and Research Foundation

Madurai.

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ABSTRACT

BACKGROUND OF THE STUDY:

This study was designed to examine the knowledge and attitude of mental illness among school teachers in Manamadurai. A descriptive study design was used. A total of sixty teachers were included in the study. Convenient sampling technique was adopted to collect the data. The knowledge was measured by 20 items of a semi structured questionnaire and attitude was assessed by modified Orientation towards mental illness scale. Data was analyzed according to objectives of study using descriptive and inferential statistics.

OBJECTIVES:

1. To identify the knowledge of teachers towards mental illness.
2. To identify the attitudes of teachers towards mental illness.
3. To find out the relationship between knowledge and attitude of teachers towards mental illness.
4. To find out the association between the knowledge of teachers towards mental illness with demographic variables such as age, gender, education, locality, previous experience with mentally ill patients.

5. To find out the association between attitude of teachers towards mental illness with demographic variables such as age, gender, education, locality, previous experience with mentally ill patients.

HYPOTHESES:

1. There will be a significant relationship between knowledge and attitude of teachers towards mental illness.
2. There will be a significant association between knowledge of teachers with selected demographic variables such as age, gender, education, locality, previous experience with mentally ill patients.
3. There will be a significant association between attitude of teachers towards mental illness with selected demographic variables such as age, education, locality, previous experience with mentally ill patients.

ASSUMPTIONS:

1. Teachers working in higher secondary schools may have inadequate knowledge about mental illness and at times may elicit negative attitudes like fear and violence.

2. The teachers who have previous experience or idea about mental illness may perceive mentally ill as less dangerous.

3. The knowledge and attitude towards mental illness differs in each individual.

4. Participants may feel hesitant to reveal true information on the questionnaires.

MAJOR FINDINGS OF THE STUDY

- Considerable number of teachers 15(25%) were below 30 years, 34(56.7%) teachers were between 31- 40 years, 3(5%) fell in the category of 50 years and above.
- The gender distribution shows that the male participants were 31(51.7%), and female were 29(48.3%).
- The great majority of teachers were Hindus 46(76.7%), 14(23.3%) were Christians.
- The percentage of unmarried teachers was 10(16.7%), married 49(81.7%) and widow 1(1.7%).
- With regard to educational status of teachers 18(30%) were undergraduates and 42(70%) were postgraduates.
- Considering the residence of teachers, 25(41.7%) were from to rural area and 35(58.3%) were from urban area.

- Place of work reveals 42(70%) teachers were from private school and 18(30%) were from Government school.
- Regarding the previous experience of teachers 34(56.7%) had no experience 26(43.3%) had known someone with mental illness.
- Majority 59(98.3%) had no family history of mental illness. One (1.7%) had family history of mental illness.
- Majority of the subjects 40(66.7%) had moderately adequate knowledge, 16(26.7%) had inadequate knowledge and 4(6.7%) had adequate knowledge.
- In case of attitude 10(16.7%) had most favorable attitude towards mental illness, 41(68.3%) had favorable attitude and 9(15%) had unfavorable attitude towards mental illness.
- There is a positive correlation between knowledge and attitude **(r =.957).** It implies that, higher the knowledge, the more the favorable attitude.
- There was a significant association between knowledge of teachers toward mental illness and demographic variables such as age, education, locality, previous experience at the level of $p<0.01$.
- There was an association between demographic variables and attitude of teachers regarding mental illness. Significant association found in age, education, locality, and previous experience at the level of $p<0.01$.

RECOMMENDATION:

Based on the findings of the study it recommends that,

- A similar study can be done in a large sample for the purpose of generalization.
- A study can be done in urban and rural setting and the results can be compared.
- A comparative study can be done with two groups.
- A similar study can be carried out and anti – stigma educational programs and campaigns may be conducted.
- A similar study can be conducted by the use of different attitude scales.

CONCLUSION:

In India 15million people are battling serious mental health problems. Nearly 50% of victims suffering serious mental health disorders go untreated. The fortunate part is most mental illnesses can be successfully treated. The Government of India also has taken special interest in mental health care in the form of National Mental Health Programme. Stigma is one of the major difficulties faced by people with mental illness, due to which they hesitate in seeking help. The mental health services are not utilized by the beneficiaries properly. Many of them suffer alone silently. By accident, we are all responsible for this situation. The researcher strongly believes appropriate information of the public and positive attitude brings great change in the life of mentally ill.

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CHAPTER I

INTRODUCTION:

Mental illness is the term used to describe a broad range of mental and emotional conditions. Mental illness is also used to refer mental impairments other than mental retardation, organic brain damage and learning disabilities. The term psychiatric disability is used when mental illness significantly interfere with the performance of major life activities such as learning, thinking, sleeping, eating and communicating among others **(World Health Organization,2001).**

Social attitudes towards people with mental disorders dates back to the prehistoric era, they believed to be ‘possessed by unclean spirits or a devil’. In American Colonial days they might be burned as witches. People diagnosed with mental illnesses live in a different space in public perception from those hospitalized for ‘physical’ conditions such as cancer or heart disease. It was perceived that mentally ill people not only acted differently but also looked different. A person hospitalized for mental illness was assumed to be dangerous, incompetent, and untrustworthy.

Negative attitudes towards people with mental illness are attributed to stigma. Stigma affects the patient’s interactions and social network, employment opportunities and quality of life in general. It also lowers the identified patient’s self esteem and contributes to a disrupted family relationship. Stigmatization can still happen for individuals whose mental illness is in remission, even if their behavior is ‘normal’ just because they

have been admitted to a psychiatric hospital. Surprisingly stigma continues to complicate the lives of the stigmatized even as treatment improved their illness. Therefore, mental illness was still perceived as an indulgence and as a sign of weakness.

The National Institute of Mental Health in the United States estimates that one in five people will experience some sort of mental illness in their lifetime and one in four people will know someone with mental illness. Mental illness is treatable and the symptoms of mental illness often can be controlled effectively through medication and or psychotherapy. But sometimes the symptoms of mental illness may go into remission, and for some people it causes continuous episodes that require ongoing treatment (**World Health Organization, 2001).**

Even though mental illness affects many people around the world, mental illness unlike other chronic physical illnesses like heart disease and hypertension, is associated with a number of misunderstandings and myths. For example, it is common for people to assume that mental illness is caused by moral weakness and or is in the possession of evil spirits. Wahass and Kent while studying the community attitudes towards the causes of auditory hallucination in Saudi Arabia and United Kingdom found out that Saudi Arabians considered supernatural causes like possession by the devil for auditory hallucination. Certain Muslim cultures placed the causes of mental illness on supernatural origins due to their belief in God's will as a determinant of all events in life. At times mental illness is also perceived as God's punishment for something bad that the person has done. **Razali and Najib (2002).**

In addition, mental illness is often associated with dangerousness and violence (Phelen, Link, Steuve&Pescosolido, 2000). According to Corrigan, Rowan, Green and Lundin (2002), public often segregate the mentally ill from the rest of society thinking they are dangerous and violent. This attribution of mentally ill with dangerousness and violence is very often due to the portrayal of mentally ill people as violent and dangerous on the media **(Lyons & Mc Loughlin, (2001).**

It was argued by Hyler, Gabbard and Schneider that presentation of mentally ill people as dangerous and violent have been so frequent in films, television, novels and comics that people accept them without a second thought.

Due to the misunderstanding and myths surrounding mental illness, mentally ill are sometimes stigmatized and may be labeled in stereotypical names such as ‘madman’, ‘morons’, lunatics’ ‘maniacs’ and ‘psycho’. In some instances mentally ill may be denied of human rights.

The most devastating and frightening experience the mentally ill has to undergo is isolation and loneliness. People tend to seclude the mentally ill from others, the family who once loved and cared for the person suddenly separates the person from the rest of the family and neglects the needs of the mentally ill person. Once institutionalized, many families refuse to take back their mentally ill family members even after recovery from the illness, forcing these already miserable people to totally lose trust in others and their condition takes a turn back into its worse. Apart from the above, mentally ill are also harassed and tortured in ways like chaining them down so that they cannot move and inflicting other bodily pain and harm **(Rotella, Gold & Adriani, 2002).**

The stereotypical labeling of the mentally ill becomes so permanent that the person is stigmatized with the stereotypical names even after recovering from the illness. People fail to understand their capabilities because of an unfortunate illness they encountered and are refused jobs for which they are qualified. This makes it difficult for the ex-mental patients to pull themselves up and gain a level of independence in the community.

Psychiatric stigmatization had led to the formation of widespread negative attitude towards mentally ill among public. Stigma and discrimination are the main obstacles faced by the mentally ill today and it is the shame and fear of this discrimination that prevents the mentally ill from seeking help and care for their disorders **(World Health Organization, 2001).**

It is important to understand about people's attitude towards mentally ill and possible factors which have lead to the formation of these attitudes. It is very likely that a person's background and experience may influence his/her attitude towards mentally ill.

Attitudes to mental illness are deeply rooted in society. Adverse attitudes affect the delivery of mental health care services. The concept of mental illness is often associated with fear of the potential threat of patients with such illness.

As we improve our medical technologies, we should also improve our attitudes. A little change in attitude in all of us is a small step. Surely a nation that tries to exercise greater graciousness can exercise a little more compassion and empathy.

NEED FOR THE STUDY:

Much of the stigma of mental illness is engrained in deep and ancient attitudes held by virtually every society on earth. The conviction that mentally ill are a dangerous threat; societies have traditionally scorned selected individuals, stir of poor scientific evidence. The vast majority of mentally ill persons never commit a violent crime. In this regard, it is important to mention the unfortunate role, which the mass media in our country play, which often shows the mental illness something to ridicule, to laugh at, or something, which is bizarre, disgusting or frightening. Such negative attitudes not only affect the person but will also spill-over to the caregiver and family members of the mentally ill. The mentally ill client, their care giver, and family, friends and social group-may be shunned, denied protection and treated as less than human beings because of what the late American sociologist Erving Goffman called their “spoiled identity”.

The stigma attached to mental illness is the greatest obstacle to the improvement of the lives of the people with mental illness and their families. The history of mental illness is long, but it is probable that intolerance to mental abnormality has become stronger in the past two centuries because of urbanization and the growing demands for skills and qualification in almost all sectors of employment.

Startling statistics about mental illness reveals that one in every 4 people, or 25% per cent of individuals, develop one or more mental

disorders at some stage in life. Today, 450 million people globally suffer from mental disorders in both developed and developing countries. Of these, 154 million suffer from depression, 25 million from schizophrenia, 91 million from alcohol use disorder and 15 million drug use disorder. Mental illnesses do not discriminate – they can affect anyone, men, women and children regardless of gender, race, ethnicity, and socio-economic status.

Mental health problems represent 5 out of 10 leading causes of disability worldwide; amounting to nearly one-third of the disability in the world. Leading contributors include depression, bipolar disorder, schizophrenia, substance abuse, and dementia.

Mental illnesses rank first among illnesses that cause disability in the United States, Canada, and Western Europe. It is predicted that by 2010, depression will be the leading cause of disability worldwide, not cancer, heart disease, diabetes, or AIDS. Mental illness is a serious public health challenge that is under-recognized as a public burden. **(World Health Organization 2007).**

Fifteen epidemiological studies in India were analyzed. It was reported that the national all-India prevalence rates for “all mental disorders’’ as 73(rural +urban) per 1000 population. The National Sample Survey Organization (NSSO) in 2005 highlighted in a survey on “disabled persons in India” that 105 people in a lakh suffered some form of mental illness. A recent report of the World Bank indicates that mental disorders are responsible for a major proportion of the disability in world and that there are indications that the situation in this aspect will worsen. More than 40% of countries have no mental health policy, and over 30% have no mental

health programs. Existing health plans frequently do not cover mental and behavioral disorders at the same level as other illnesses, creating significant economic difficulties for patients and their families. One of the identified reasons for low support for mental health is the stigma attached to mentally ill individuals.

India, the second most populated country of the world with a population of 1.027 billion, is a country of contrasts. The population is predominantly rural, and 36% of people still live below poverty line. There is a continuous migration of rural people into urban slums creating major health and economic problems. India is one of the pioneer countries in health services planning with a focus on primary health care. However, only a small percentage of the total annual budget is spent on health. Mental health is part of the general health services, and carries no separate budget. The National Mental Health Programme serves practically as the mental health policy. Recently, there was an eight-fold increase in budget allocation for the National Mental Health Programme for the Tenth Five-Year Plan (2002–2007). India is a multicultural traditional society where people visit religious and traditional healers for general and mental health related problems. However, wherever modern health services are available, people do come forward. India has a number of public policy and judicial enactments, which may impact on mental health. **(India mental health country profile).**

In the past decade, several professional associations have initiated awareness campaigns on mental illness. In devoting The World Health Day 2001 and the World Health Report 2001 to mental health, the World Health Organization (WHO) stated that mental illness was ignored and mental health is essential to the over-all well-being of individuals, societies, and

countries. The American Psychiatric Association Assembly and the Board of Trustees approved a Position Statement on discrimination against persons with previous psychiatric treatment to facilitate their full participation in society.

In India close to 15 million people are battling serious mental health problems. Some 30 million are suffering mild forms of mental illnesses. Nearly 50% of victims suffering serious mental disorders go untreated. Though Government of India has taken special interest in mental health care in the form of National Mental Health Programme, District Mental Health Programme, District Hospital Psychiatric Units, and General Hospital Psychiatric Units, we still have to go a long way in achieving the goal of "Mental Health for all". There are several reasons for not achieving the target, the major one being lack of rural partnership in the mental health delivery.

No programme is successful without the involvement of its consumers. The rural partnership can be promoted through the following members in the community, who always live with the people. Village leaders, teachers, mahila mandals, youth organizations, health workers, postman and others. Each one of them can play a unique role in the promotion of mental health and prevention of mental disorders. **(The Nursing Journal of India).**

Fortunately the researcher had an opportunity to come across many literatures of public awareness concerning mental illness. There was a modest uncertainty of choosing the population. Long ago, American sociological association studied perception of mental illness among public school teachers. The results discovered that teachers are better able than the

general public to identify symptoms of mental illness. The integration of mental health into primary care also insist that, mental disorders are identified and directed by anganwadi workers, primary care centre staff, panchayat members, and school teachers (World Health Report 2008). This was the motive to the researcher to fix on the problem statement and the population.

STATEMENT OF THE PROBLEM:

"A STUDY TO ASSESS THE KNOWLEDGE AND ATTITUDE TOWARDS MENTAL ILLNESS AMONG TEACHERS WORKING IN THE SELECTED SCHOOLS OF SIVAGANGAI DISTRICT".

OBJECTIVES:

1. To identify the knowledge of teachers towards mental illness.
2. To identify the attitudes of teachers towards mental illness.
3. To find out the relationship between knowledge and attitude of teachers towards mental illness.
4. To find out the association between the knowledge of teachers towards mental illness with demographic variables such as age, gender, education, locality and previous experience of mentally ill patients.
5. To find out the association between attitude of teachers towards mental illness with demographic variables such as age, gender, education, locality and previous experience of mentally ill patients.

HYPOTHESIS:

There will be a significant relationship between knowledge and attitude of teachers towards mental illness.

There will be a significant association between knowledge of teachers with selected demographic variables such as age, gender, education, locality and previous experience with mentally ill patients.

There will be a significant association between attitude of teachers towards mental illness with selected demographic variables such as age, education, locality and previous experience with mentally ill patients.

OPERATIONAL DEFINITIONS:

KNOWLEDGE:

Information possessed by the teachers regarding the nature of mental illness and comprehension about mental health which is measured by self administered questionnaire.

ATTITUDE:

Favorable and unfavorable feelings, concern, opinion and views of teachers towards mental illness.

MENTAL ILLNESS:

Mental illness is said to be unsuccessful adaptation to stressors from the environment, evidenced by deviated thoughts, feelings, and behaviors.

TEACHERS:

Individuals are trained to teach in the higher secondary schools of Sivagangai district.

ASSUMPTIONS:

1. Teachers working in higher secondary schools may have inadequate knowledge about mental illness and at times may elicit negative attitudes like fear and violence.

2. The teachers who have previous experience or idea about mental illness may perceive mentally ill as less dangerous.

3. The knowledge and attitude towards mentally ill differs in each individual.

4. Participants may feel hesitant to reveal true information on the questionnaires.

DELIMITATIONS:

1. The study covers those who are working in higher secondary schools.
2. Those are available and willing to participate at the time of study.

PROJECTED OUTCOME:

The study gives the clear understanding of the knowledge and attitudes of teachers towards mental illness. The outcome of the study helps the mentally ill patients in the community. Teachers formulate appropriate positive attitudes towards psychiatric patients. Awareness of mental illness reduces the stigmatization of people with mental disorders.

CONCEPTUAL FRAMEWORK:

The conceptual framework is a group related ideas, statements or concepts. The term conceptual model is often used interchangeably with conceptual framework, and sometimes with grand theories, those that articulate a broad range of significant relationship among the concepts of a discipline **(Kozier Barbara 2005)**.

The conceptual framework serves as a springboard for theory development, theoretical and context, the importance of the study, where a model symbolically represents a phenomenon. The present study is aimed at assessing the knowledge, attitude regarding mental illness among teachers.

The conceptual framework for this study is based on Health Belief Model. Health beliefs are person's opinions and attitude about the health and illness. They may be based on factual information and using information.

Rosenstock (1974), Beckers Health Belief Model addressed the relationship between the person's belief and behavior. It is a way of perception and understanding of teachers in relation to knowledge and attitude towards mental illness. This model helps the nurses to understand various behaviors including individual perception, belief and various behaviors in order to plan the most effective care in this context the investigator felt that the Becker's model is suitable as conceptual framework for this study.

INDIVIDUAL PERCEPTION

The first component in this model is the individual perception of susceptibility an illness in this study teachers perception regarding mental

illness are thought to be influenced by age, sex, martial status, educational status, previous experience with mental ill and family history, year of experience, individual perception may very with these variables.

MODIFYING FACTOR

In this study modifying factor are the knowledge and attitude regarding mental illness. These factors can be modified through health education. The knowledge of teachers about illness was assessed with the help of questionnaire. Attitude of teachers was assessed with the help of orientation towards mental illness scale.

The knowledge level of teachers was graded as adequate, moderate and inadequate knowledge. The attitude level of teachers was graded as most favorable, favorable and unfavorable.

LIKELIHOOD OF ACTION

It refers to perceived benefit of preventive action minus perceived threat of preventive action. In this study the individual perception and modifying factor together influence perceived threat of diseases. The health education should also be given based on teacher’s level of knowledge and attitude. Therefore the investigator planned a health education using different aids to improve teacher’s knowledge regarding mental illness.

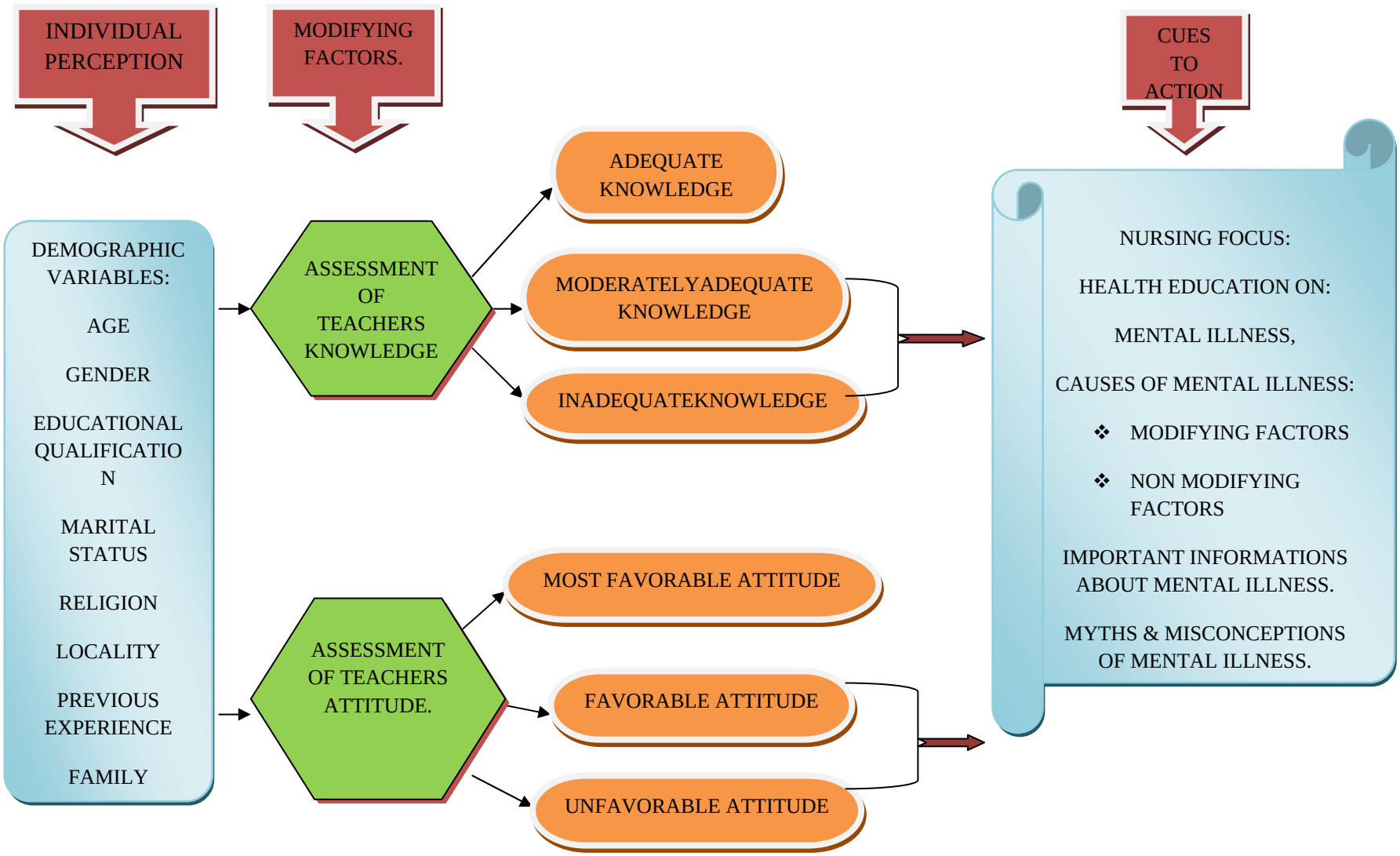

FIGURE 1. CONCEPTUAL FRAMEWORK BASED ON ROSENSTOCK'S (1974) HEALTH BELIEF MODEL.

(MODIFIED)

CHAPTER II

REVIEW OF LITERATURE

This chapter presents a review of selected literature relevant to the present study. Review of literature is an important step in the development of the research project, and in broadening the understanding and developing an insight into the problem area. It further helps in developing the broad conceptual context, in which the problem fits, methodology, construction of tool, analysis of data.

The information gathered is categorized under the following heading:

Sec A: Literature related to knowledge towards mental illness

Sec B: Literature related to attitude towards mental illness.

SECTION A:

LITERATURE RELATED TO KNOWLEDGE TOWARDS MENTALILLNESS:

Kaoru Yamamoto and Henry F.dizney (2005) conducted a study on mental health knowledge among student teachers in two universities namely university of Oregon and Lowa. A total of 180 student teachers were selected using a four item questionnaire to assess their mental health knowledge. Females gave consistently higher estimates than males, although both sexes were ascribed incidence figures not significantly different from each other. These results suggest needed improvement in the mental health education of teachers.

Oye Gureje et al., (2005) carried out a community study of knowledge and attitude to mental illness in Nigeria. A multistage clustered sample of household respondents was studied in three states in the Yoruba – speaking

parts of Nigeria. A total of 2040 individuals participated. Poor knowledge of causation was common. Negative views of mental illness were widespread, with as many as 96.5% believing that people with mental illness are dangerous because of their violent behavior. Most would not tolerate even basic social contacts with a mentally ill person. **82.7%** would be afraid to have a conversation with a mentally ill person and only 16.9% would consider marrying one. There is widespread stigmatization of mental illness in the Nigerian community. Negative attitudes to mental illness may be fuelled by notions of causation that suggest that affected people are in some way responsible for their illness, and by fear.

A.F. Jorm (2000) has done a study on public knowledge and beliefs about mental disorders in Australia. A narrative review within a conceptual framework method was used. The result shows that many members of the public cannot recognize specific disorders or different types of psychological distress. They differ from mental health experts in their beliefs about the causes of mental disorders and the most effective treatments. Attitudes which hinder recognition and appropriate help-seeking are common. Much of the mental health information most readily available to the public is misleading. However, there is some evidence that mental health literacy can be improved. In conclusion, if the public's mental health literacy is not improved, this may hinder public acceptance of evidence-based mental health care. Also, many people with common mental disorders may be denied effective self-help and may not receive appropriate support from others in the community.

Maureen Mickus, et al., (2000) the study explored knowledge of mental health benefits and preferences for providers among the general public. Analysis was based on a telephone survey of 1,358 adults randomly sampled throughout Michigan in 1997–1998. The result shows a large proportion of the respondents were uninformed about their mental health benefits. One-quarter of the sample

were unsure if their health plan even included mental health services. Forty-three percent of the sample believed that mental health benefits were equal to benefits provided for general medical services. In answer to a survey question that summarized payment restrictions for psychiatric services and counseling under Medicare, nearly a quarter of older respondents indicated that they would not seek care even when needed. In the overall sample, the majority of respondents said they would initially seek care from their primary care physician for a mental health problem, although responses varied by age. Persons over age 65 were significantly more likely to seek assistance from their primary care doctor than were younger persons. The study concludes the general public lacks information about important mental health benefits, and this lack of information may represent a barrier in their seeking care when needed. Given the overriding preference for primary care providers to treat mental health problems, particularly among older adults, mental health issues should be given more attention at all levels of primary care education.

SECTION B:

LITERATURE RELATED TO ATTITUDE TOWARDS MENTALLY ILL PEOPLE.

Pol Merkur Lekarski, (**2009**) completed a study on stigma and related factors in Poland. In his study the most important socio – demographic factors influencing attitudes towards mentally ill people exemplified them by scientific literature on mental illness stigma. Profession, frequency of contact with mentally ill persons, level of mental health literacy, own experience, education level, culture - related factors, over all orientation, gender and age are the most

relevant factors which influence perception of people suffering from mental disorders. Majority of campaigns concerning change of attitude towards mentally ill people consist in enhancement of mental health awareness in society.

Mansouri et al; (2009) have done a study on the change in attitude and knowledge of health care personnel and general population in the Iran Medical University. Electronic bibliographic databases were used. The result of the study shows that six articles met the inclusion criteria and entered the review. All of these studies showed an improvement in the attitude and knowledge of the studied population. It is concluded that a short term training improved knowledge and attitude of the population and health personnel immediately after the intervention. There is also evidence for a long term change in the attitude and knowledge of general population after short term training.

Adewuya Ao, Makanjuola ro. (2008) has done a study on social distance towards people with mental illness in southwest Nigeria. A cross – sectional survey was carried out in which 2078 samples were selected from three different communities. Social distance towards people with mental illness was measured with a modified version of the Bogardus Social distance Scale. The study findings showed that level of desired social distance towards the mentally ill was seen to increase with the level of intimacy required in the relationship, with 14.5% of the participants categorized as having low social distance, 24.6% as having moderate social distance and 60.9% as having high social distance towards the mentally ill. There is an emerging evidence of a high level of social distance and stigmatization of mental illness in sub – Saharan Africa. There is need to incorporate anti – stigma educational programmes into the mental health policies of countries in Sub – Saharan Africa. Such policy

should include community education regarding the causation, manifestation, treatment and prognosis of mental illness.

Des Courtis N et al., (2008) made a study on Beliefs about the mentally ill: a comparative study between healthcare professionals in Brazil and in Switzerland. Mental health professionals presented a case vignette describing a person suffering from a major depression as well as related treatment proposals. Furthermore, general attitudes towards people with mental illness were assessed. Study finding shows that both samples had scores for social acceptance. Brazilian mental health professionals displayed a more positive attitude towards community psychiatry whereas the Swiss sample showed more stigmatization and social distance, and a more positive attitude towards psychopharmacology. Recognition of the case vignette was significantly better in Brazil than in Switzerland (94.7% versus 71%). Mental health professionals in Brazil were more conservative/medically oriented in their treatment propositions whereas professionals from Switzerland also proposed social interventions and alternative treatment strategies. It is identified that there are some major differences in attitudes towards people with mental illness between mental health professionals in Switzerland and Brazil. With respect to therapeutic interventions, the different healthcare systems as well as the cultural differences seem to have an impact.

Adewuya Ao, Oguntade AA, (2007) completed a study on Doctor's attitude towards people with mental illness in Western Nigeria. Total of 312 Medical Doctors from eight select health institutions participated in this study. It had been suggested that those more knowledgeable about mental illness are less likely to endorse negative or stigmatizing attitudes. The study reports that beliefs in supernatural causes were prevalent. The mentally ill were perceived as dangerous and their prognosis perceived as poor. High social distance was found amongst 64.1% and the associated factors include not having a family

member /friend with mental illness (OR 7.12, 95% CI 3.71- 13.65), age less than 45 years (OR 2.33, 95% CI 1.23- 4.40), less than 10 years of clinical experience (OR 6.75, 95% CI 3.86- 11.82) and female sex (OR 4.98, 95% CI 2.70- 9.18). Significant finding of this study in culturally enshrined beliefs about mental illness were prevalent among Nigerian doctors. A review of medical curriculum is needed and the present anti-stigma campaigns should start from the doctors.

Angermeyer Mc, Dietrich s. (2006) prepared a review of population based attitude research in psychiatry during the past 15 years. An electronic search of the literature was carried out for studies on public beliefs about mental illness and attitudes towards the mentally ill published between 1990 and 2004. Thirty three national studies and 29 local and regional studies were identified, mostly from Europe. Although the majority are of descriptive nature, more recent publications include studies testing theory – based models of the stigmatization of mentally ill people, analyses of time trends and cross – cultural comparisons, and evaluations of anti stigma interventions. Their review reveled that attitude research in psychiatry has made considerable progress over 15 years. The authors concluded that there is much to be done to provide an empirical basis for evidence – based interventions to reduce misconceptions about mental illness and improve attitude towards persons with mental illness.

R.A. Olade (2006) had done a comparative study on attitudes towards mental illness among post – basic nursing students with science students in Canada. Totally 37 registered general nurses from the Faculty of Medicine and 15 science students from the Faculty of Science participated. Responses on the OMI scale questionnaire items on attitudes towards mental illness were examined. The study result shows that nurses scored higher on interpersonal etiology and mental hygiene ideology.

Bell et al. (2006) completed a comparative study on pharmacy students' attitudes toward types of mental illnesses and provision of services in Florida. Convenient sampling technique was used. Pharmacy students at two urban schools of pharmacy were recruited. A total of 314 students were participated in this study. Study results show that students have less stigma for depression and schizophrenia than others in pharmacy .Students significantly more willing to provide services to those with asthma than mental illness. Findings of the study clearly indicate the need for developing effective strategies to reduce stigma of mental illness among pharmacy students.

Buizza C, et al, (2005) carried out a study on Community attitudes towards mental illness and socio – demographic characteristics in Italy. This study aimed to assess the association between socio – demographic characteristics and community attitudes towards mentally ill people. Stratified sampling method was used. Totally 280 subjects were selected and conducted by telephone. Finally, 174 subjects expressed their willingness to collaborate. The instruments used were: a semi structured interview; the Community Attitudes to the mentally ill (CAMI) inventory, which is composed by 40 statements. The results of this study outline the need to promote interventions focused to improve the general attitude towards people with mental illness and to favor specific actions in order to prevent or eliminate prejudices in subgroups of the population.

Lauber C, Carlos N, Wulf R. (2005) study on Lay believes about treatments for people with mental illness and their implications for anti stigma strategies. Survey method was used to cover the total subjects of 1737. The result of this study shows that medical treatment proposals are influenced by adequate mental health literacy; however, they are also linked to more social distance toward people with mental illness.

Angermeyer and Matschinger, (2004) examined if public attitudes have improved over the last decade or not. In 2001, a representative survey was carried out among the adult population of the "old" Federal Republic of Germany using the same methodology as in a previous survey in 1990. Regarding emotional reactions of the respondents towards people with depression, the findings were inconsistent. While there was an increase in the readiness to feel pity and also a slight increase in the tendency to react aggressively, the expression of fear remained unchanged. The public's desire for social distance from people with depression was as strong in 2001 as it had been in 1990.

Ahmad H, Mas Ayu, Rawiyah R (2004) conceded a comparative study on attitudes of paramedics towards mentally ill patients at University of Malaya Medical centre, Kuala Lumpur. The study was carried out at two hospitals. The samples comprised of 95 paramedics from a general hospital and 69 paramedics from a mental institution. The two dependent measures (social distance scale and dangerousness scale) were used to assess the attitude of paramedics towards mental illness. The results of the study suggested that before the paramedics can educate the public about mental illness, they themselves must be able to understand and must not have a negative attitude towards the mentally ill.

Mohammed Kabir et al, (2004) had done a study on perception and beliefs about mental illness among adults in northern Nigeria. Totally 250 adults participated in this study. A cross sectional study design was used. The study result shows that almost half of the respondents harbored negative feelings towards the mentally ill. Literate respondents were seven times more likely to exhibit positive feelings towards the mentally ill as compared to non – literate subjects (OR = 7.6, 95% confidence interval = 3.8 – 15.1). This study

demonstrates a that better understanding of mental disorders among the public would allay fear and mistrust about mentally ill persons in the community as well as lessen stigmatization towards such persons.

Mistic and Turan, (2003) examined the opinions and attitudes of first and final year medical students towards mentally ill patients in order to compare the attitudes of the two groups to see the effects of medical education and confronting of the patients, and to evaluate the stigmatization of the mentally ill by future medical professionals. A questionnaire comprising 19 questions regarding opinions and attitudes towards mental illness was administered to the first and final year medical students. There were 308 students who filled out the questionnaire, which was 81% of the total of first and final year students. Observation and talking were the most common preferred choices in both of the groups, for recognizing a psychiatric patient. The final year student's felt more indifferent, less fear, and less compassion when they saw a psychiatric patient.

Samir Al – Adwi et al, (2002) did a comparative study on perception of and attitude towards mental illness among medical students and the relatives of psychiatric patients in Oman. The study found no relationship between attitudes towards patients with mental illness, and demographic variables such as age, education level, marital status, sex and personal exposure to people with mental illness. Both medical students and the public rejected a genetic factor as the cause of mental illness; instead they favored the role of spirits as the etiological factor for mental illness. There were favorable responses on statements regarding value of life, family life, decision making – ability, and the management and care of mental illness. In conclusion, this study largely supports the view that the extent of stigma varies according to the cultural and sociological backgrounds of each society.

Chung Kf, Chen Ey, Liu CS., (2001) conducted a study on University students' attitudes towards mental patients and psychiatric treatment in Hong Kong. Random sampling techniques were used and totally 308 university undergraduates participated in this study. The study finding shows that greater social distance was associated with non medical field of study, no previous contact with the mentally ill and female gender. Subjects without previous contact with mentally ill individuals kept greater distance from a discharged mental patient receiving psychiatric care than a mental patient who did not require medications or psychiatric follow - up. They have concluded that reducing stigmatization was discussed.

Kai – Fong Chan (2000) carried out a study on sex differences in opinion towards mental illness of secondary school students in Hong Kong. A total of 2,223 secondary school students, drawn by a random sample, completed a 45 – item questionnaire on Opinion about Mental Illness in Chinese Community with a six point Likert Scale. Results showed that girls scored higher regarding benevolence. Boys were found to have more stereotyping, restrictive, pessimistic, and stigmatizing attitudes mental illness.

CHAPTER III

RESEARCH METHODOLOGY

This chapter deals with the description of different steps which are taken by the investigator for the present study. It includes research approach, setting, and sampling, sampling techniques, tools for data collection, pilot study and plan for data collection.

RESEARCH APPROACH:

Research approach used for this study is quantitative approach.

RESEARCH DESIGN:

The research design used for the study is descriptive design.

SETTING OF THE STUDY:

The study was conducted at selected schools in Sivagangai District. Totally two school teachers participated in this study.

The okur velayan chettiyar (O.V.C.) higher secondary school is approximately 4 km away from Matha College of Nursing. The student strength is around 750. The school comprise of 46 teachers. The 30 male teachers + 16 female teachers. It is a co - education school consists of 37 sections from 6^{th} to 12^{th} standard. The school functions from 9am to 4.30pm.

The Government Girl's Higher Secondary School at Manamadurai. This is about 6- 8 km away from Matha College of Nursing. Total students strength is roughly 2500. There are 50 teachers out of which 10 are male and the remaining 40 are female teachers. There are about 30 sections from 6^{th} to 12^{th} standard. The school functions from 9am to 4.30pm.

POPULATION:

The target population selected for this study comprised of teachers working in higher secondary schools.

SAMPLE SIZE:

The aggregate of 60 teachers were selected for this study.

SAMPLING TECHNIQUE:

The sampling technique used in the study is convenient sampling. This entails the use of most readily available teachers in study until the desired sample size is reached. Considering the short span of time available for research the investigator used this method of sample selection so that the required sample size is achieved.

CRITERIA FOR SAMPLE SELECT

INCLUSION CRITERIA:

1. Teachers who work in higher secondary schools.
2. Teachers of both sexes.
3. Those are willing to participate.
4. Those who have more than two years of experience as a teacher.

EXCLUSION CRITERIA:

1. The subjects who are recently appointed.
2. Those who are not willing to participate in the study.
3. Teachers who are not available and on long leave.

TECHNIQUE AND TOOL:

According to Treeca T. the instrument selected in the research should as far as possible be the vehicle that would best obtaining data for drawing conclusions pertinent to the study.

DEVELOPMENT OF THE TOOL:

The knowledge questionnaire constructed by the researcher is based on the facts about mental illness. This consists of causes, treatment, facilities,

human rights, law related to mental illness and rehabilitation. Totally 20 items are used to assess the knowledge. In order to assess the attitude towards mental illness **ORIENTATION TOWARDS MENTAL ILLNESS SCALE (PRABHU 1983)** was modified and used. Expert's opinion and suggestions were also taken for the development of the tool.

DESCRIPTION OF THE STUDY TOOL:

SECTION I

Demographic variables such as age, religion, educational status, occupation, place of work, years of experience.

SECTION II

PART I

Semi structured questionnaire was used to assess the knowledge towards mental illness.

PART II

ORIENTATION TO THE MENTAL ILLNESS SCALE (OMI) (PRABHU, 1983). MODIFIED:

The tool was developed by Prabhu (1983). It is a 67-item scale, was modified by the researcher which aims at measuring the individual's orientation to mental illness. It is most useful while measuring the orientation of an Indian, urban, literate, English speaking, and lay population. It taps various aspects of orientation to mental illness. The original scale provides scores on 13 factors, which can be grouped into four areas. The modified scale consists of 30 items. It has 22 negative statements, 4 positive statements, 4 no opinion statements. The 5 point Likert scale has been used to measure the ratings. This scale has a maximum score of 150.

SCORE INTERPRETATION:

SECTION I

The demographic variables are not scored, but used for descriptive analysis.

SECTION II

PART I

The knowledge questionnaire consists of 20 items. The format is true or false. In this 1 indicates the correct response and 0 indicates incorrect response. Based on the score knowledge were categorized as adequate knowledge, moderately adequate knowledge, and inadequate knowledge. Those scored above 12 consider as people of adequate knowledge, the score of 10 – 12 consider as people of moderately adequate knowledge and the score of below 10 regarded as inadequate knowledge.

PART II

The attitude was scored on a 5-point Likert format ranging from 1-5, where one indicates complete disagreement; five indicates complete agreement and three indicates uncertainty with the item. The higher the score, the greater the degree of favorable orientation towards mental illness indicated. Approximately 25 minutes is needed for the administration of scale. Based on the score it has been categorized as most favorable attitude, favorable attitude and unfavorable attitude. The score of above 106 regarded as most favorable attitude, the score of 80 – 106 measured as favorable attitude, and below 80 regarded as unfavorable attitude towards mental illness.

TESTING OF THE TOOL:

VALIDITY:

The constructed tool along with blue print and objectives of the study were given to five experts for content validity. After establishment the validity of the tool was translated into Tamil and again translated into English to validate the language.

RELIABILITY:

The test retest method was used to establish the reliability of the questionnaire to assess the problems faced by teachers. The knowledge score reliability was r = 0.46. The modified form of orientation scale reliability r = 0.49. This 'r' values was found to be reliable.

PILOT STUDY:

The pilot study was conducted with the Government Higher Secondary School teachers. The study was carried out on six teachers who fulfilled the inclusion criteria of the sample. It was carried in the similar way as the final study would be done. In order to test the feasibility and practicability, it was conducted after obtaining permission from the school. The results were analyzed based on the score obtained by the teachers and the study was found to be feasible.

PROCEDURE FOR DATA COLLECTION:

The data was collected for a period of six weeks in Manamadurai schools. The time scheduled for data collection was from 10am to 3pm. Before the data collection the investigator obtained the formal permission from the Head Masters of each school. The investigator entered the staff room at 10am. The available teachers were explained about the purpose of the study the consent was obtained. The questionnaire was circulated and collected back within 25 minutes. In a day the investigator could able to collect 3 – 4 teachers. The

teacher's knowledge was assessed through interview by using semi structured knowledge questionnaire. Similarly the attitude of teachers was assessed by using modified form of orientation towards mental illness scale. A total of 60 subjects participated who fulfilled inclusion criteria. The average time taken for the interview was approximately 25 minutes. On completion of the questionnaire each one has given time to clarify one's doubts.

DATA ANALYSIS:

The data were statistically analyzed by using descriptive (frequency, percentage, mean) and inferential statistics. Descriptive statistics was used to find the level of knowledge and attitude. Chi square test was used to find out the association between demographic variables and knowledge, attitude. Correlation co – efficient 'r was computed to find out the relationship between knowledge and attitude.

PROTECTION OF HUMAN SUBJECTS:

The study was done after the approval of the dissertation committee. Permission was obtained from the Head Masters of each school. Verbal consent was obtained from the subjects and assurance was given to the subjects that confidentiality would be maintained.

CHAPTER IV

DATA ANALYSIS AND INTERPRETATION OF DATA:

This chapter deals with statistical analysis. Statistical analysis is a method of rendering quantitative information in meaningful and intelligible manner. Statistical procedure enables the researcher to organize, analyze, evaluate, interpret and communicate numerical information meaningfully.

OBJECTIVES:

1. To identify the knowledge of teachers towards mental illness.
2. To identify the attitudes of teachers towards mental illness.
3. To find out the relationship between knowledge and attitude of teachers towards mental illness.
4. To find out the association between the knowledge of teachers towards mental illness with demographic variables such as age, gender, education, locality, previous experience with mentally ill patients.
5. To find out the association between attitude of teachers towards mental illness demographic variables such as age, gender, education, locality, previous experience with mentally ill patients.

PRESENTATION OF DATA:

The data about knowledge and attitude of mental illness among teachers were collected and was tabulated, analyzed and interpreted under the following sections.

SECTION I

Distribution of demographic variables of teachers.

SECTION II

- Frequency and percentage distribution of knowledge regarding mental illness among teachers.
- Frequency and percentage distribution of attitude regarding mental illness among teachers.

SECTION III

Relationship between knowledge and attitude regarding mental illness among teacher.

SECTION IV:

Association between knowledge and demographic variables.

SECTION V:

Association between attitude and demographic variables.

SECTION: I

TABLE I

Frequency and percentage distribution of teachers on the basis of demographic variables.

S.NO.	DEMOGRAPHIC CHARACTERISTICS	FREQUENCY	PERCENTAGE %
1.	**AGE IN YEARS:**		
	1. Below 30 years.	15	25
	2. 31 – 40 years.	34	56.7
	3. 41 – 50 years	8	13.3
	4. 50 and above	3	5
2.	**GENDER:**		
	1. Male	31	51.7
	2. Female	29	48.3
3.	**RELIGION:**		
	1. Hindu	46	76.7
	2. Christian	14	23.3
	3. Muslim	-	-
	4. Others	-	-
4.	**MARITAL STATUS:**		
	1. Unmarried	10	16.7
	2. Married	49	81.7
	3. Widow	1	1.7
	4. Divorced	-	-
5.	**EDUCATIONAL STATUS:**		
	1. Undergraduate	18	30
	2. Postgraduate	42	70

6.	**LOCALITY:**		
	1. Rural	25	41.7
	2. Urban	35	58.3
7.	**PLACE OF WORK:**		
	1. Private school	42	70
	2. Government school	18	30
8.	**PREVIOUS EXPERIENCE:**		
	1. Yes	26	43.3
	2. No	34	56.7
	FAMILY HISTORY:		
9.	1. Yes	1	1.7
	2. No	59	98.3

Table I reveals that out of 60 teachers 15(25%) were below 30 years, 34(56.7%) teachers were between 31- 40 years, 3(5%) fell in the category of 50 years and above.

The gender distribution shows that the male participants were 31(51.7%), and female were 29(48.3%).

The great majority of teachers were Hindus 46(76.7%), 14(23.3%) were Christians.

The percentage of unmarried teachers was 10(16.7%), married 49(81.7%) and widow 1(1.7%).

With regard to educational status of teachers 18(30%) were undergraduates and 42(70%) were postgraduates.

Regarding the residence of teachers 25(41.7%) belonged to rural area and 35(58.3%) were from urban area.

Place of work reveals that 42(70%) teachers were from private school and 18(30%) were from Government school.

With respect to previous experience of teachers, 34(56.7%) had no experience with mental illness 26(43.3%) had known someone with mental illness.

Majority of 59(98.3%) had no family history of mental illness. And 1(1.7%) had family history of mental illness.

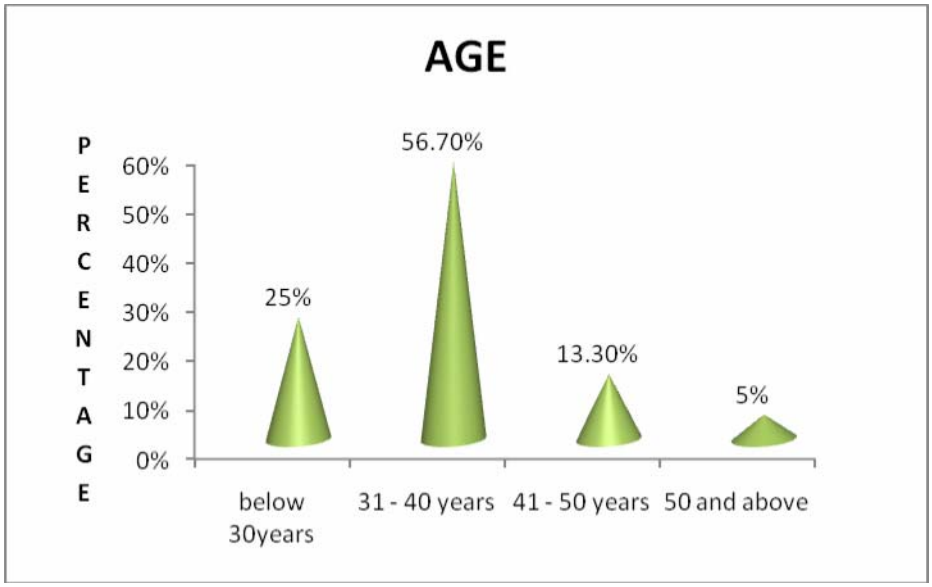

Figure 2: Distribution of the samples in terms of age in years.

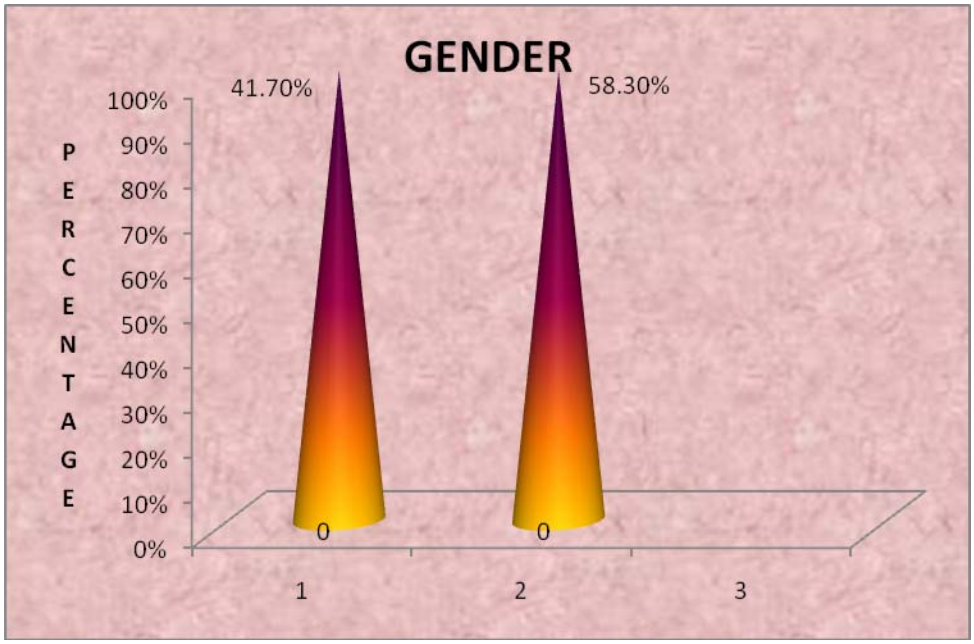

Figure 3. Distribution of the samples in terms of gender.

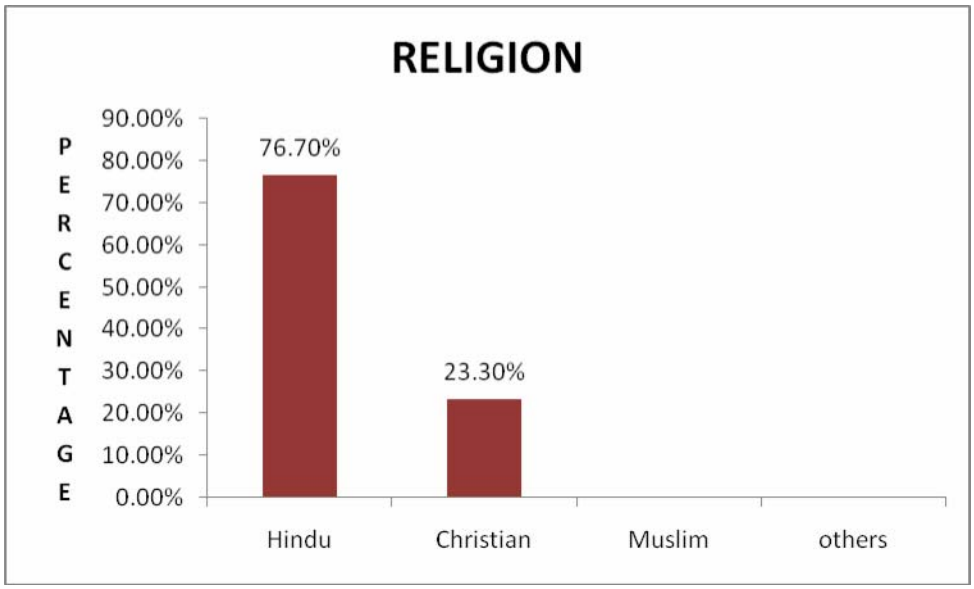

Figure 4. Distribution of samples according to religion.

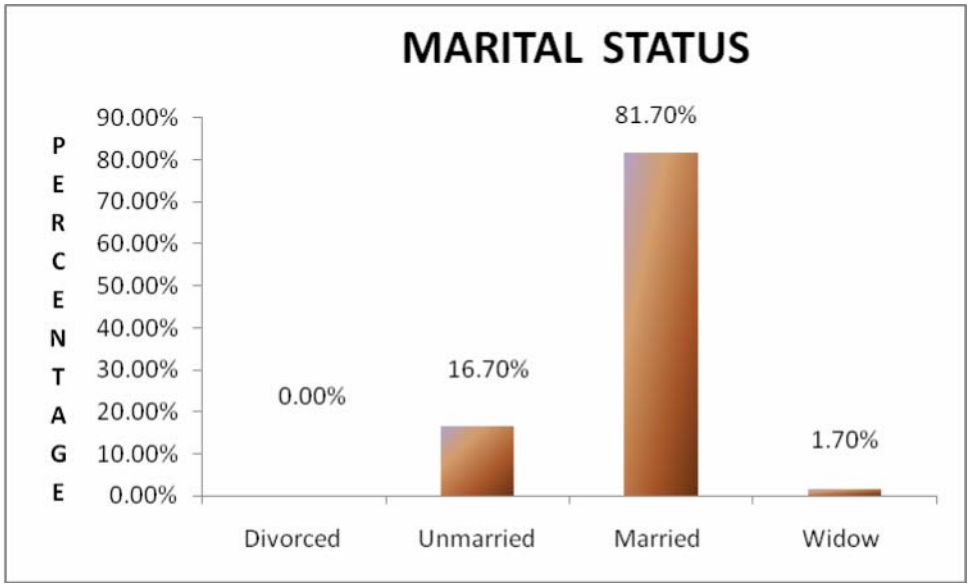

Figure 5. Distribution of samples according to their marital status.

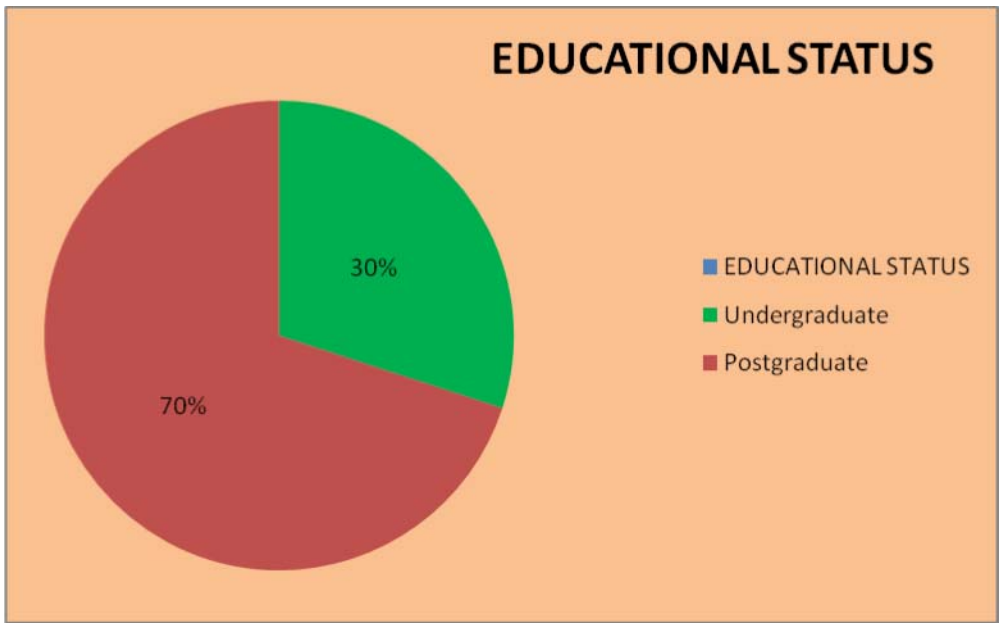

Figure 6. Distribution of samples according to their educational status.

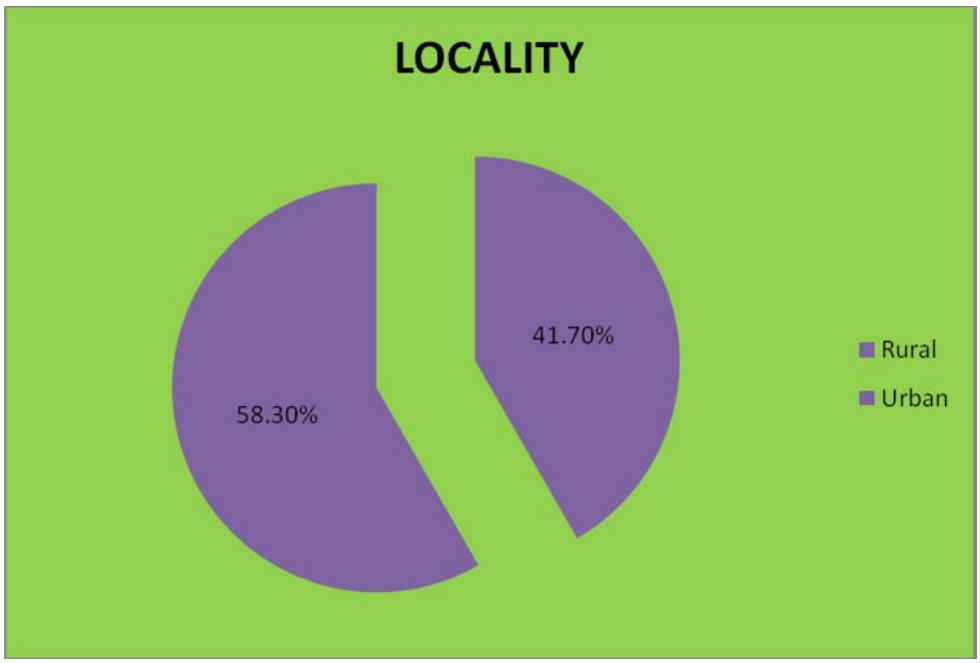

Figure 7. Distribution of samples on the basis of locality.

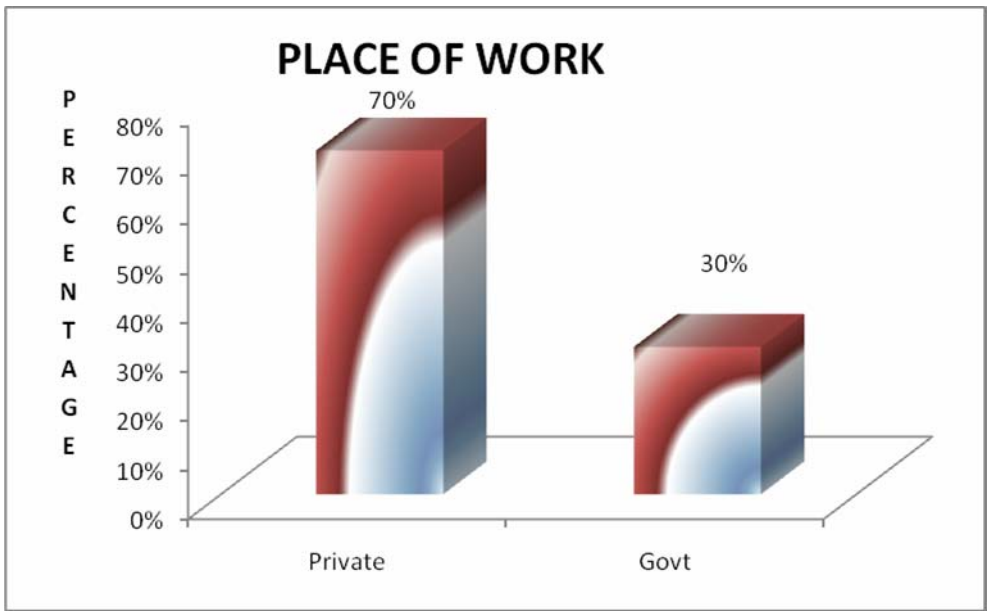

Figure 8. Distribution of samples on the basis of place of work

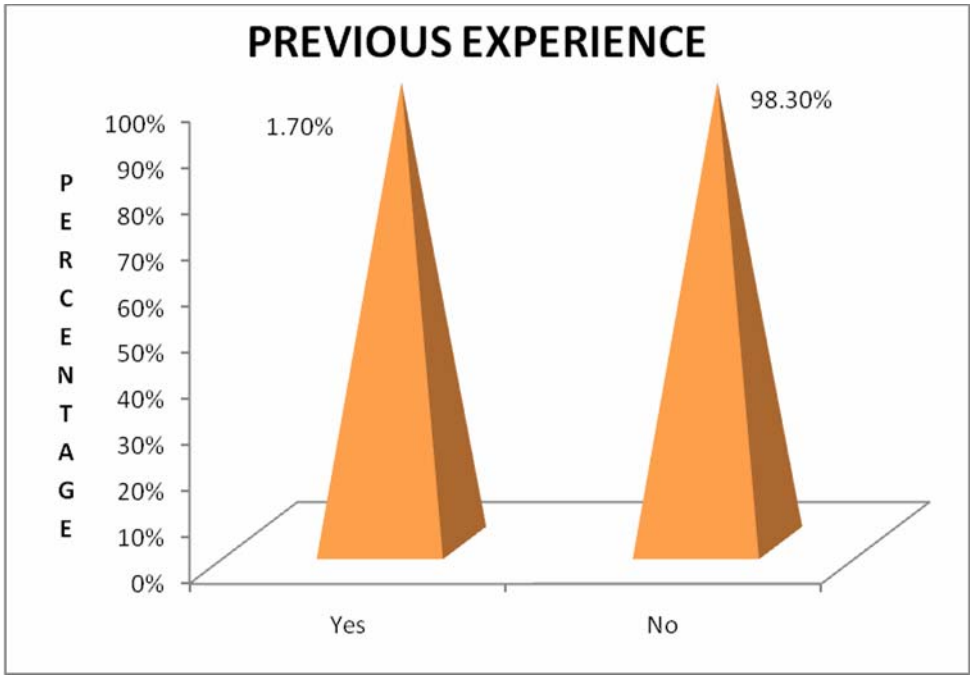

Figure 9. Distribution of samples on the basis of previous experience.

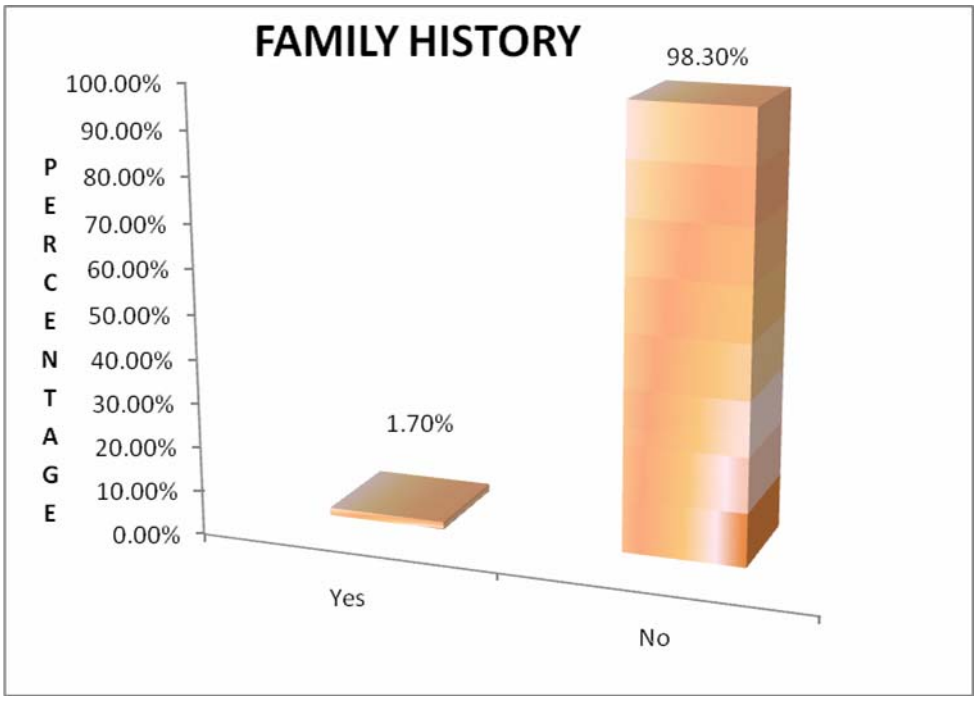

Figure 10. Distribution of samples in terms of family history.

SECTION: II

TABLE II - LEVEL OF KNOWLEDGE:

Frequency and percentage distribution of knowledge regarding mental illness among teachers.

S.NO.	LEVEL OF KNOWLEDGE	FREQUENCY N=60	PERCENTAGE
1.	Low	16	26.7
2.	Medium	40	66.7
3.	High	4	6.7

Table II reveals that majority of the subjects 40(66.7%) had moderately adequate knowledge, 16(26.7%) had inadequate knowledge and 4(6.7%) had adequate knowledge.

TABLE III – LEVEL OF ATTITUDE:

S.NO.	LEVEL OF ATTITUDE	FREQUENCY N=60	PERCENTAGE
1.	Unfavorable	9	15
2.	Favorable	41	68.3
3.	Most favorable	10	16.7

Table III shows that 41(68.3%) had favorable attitude towards mental illness, 10(16.7%) had most favorable attitude and 9(15%) had unfavorable attitude towards mental illness.

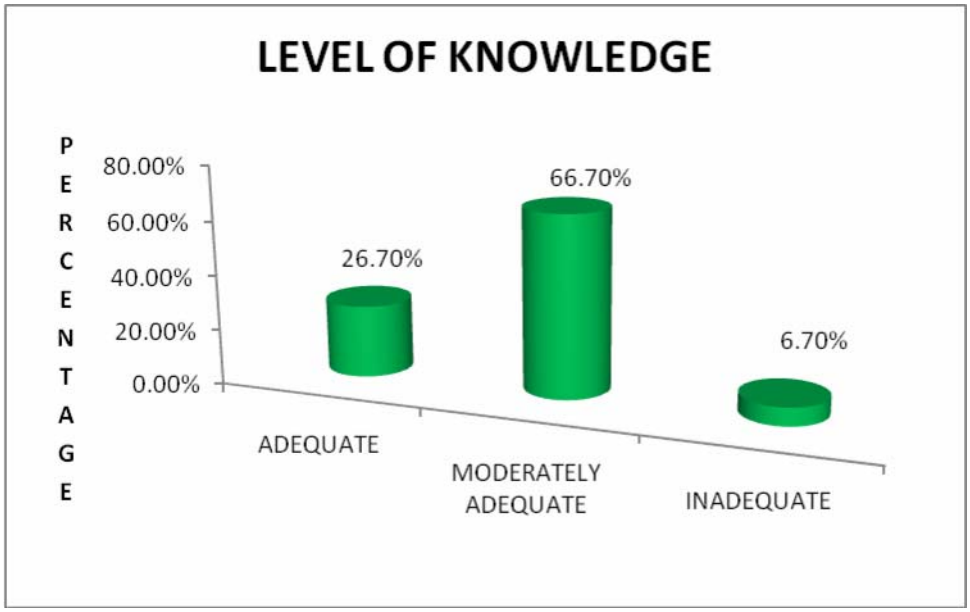

Figure 11. Distribution of samples in terms of level of knowledge

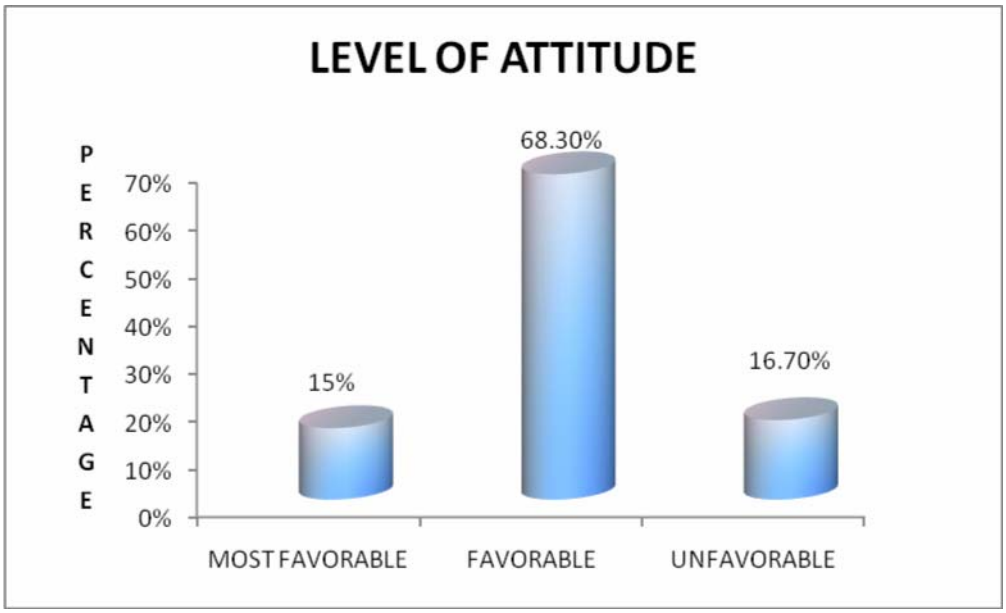

Figure 12. Distribution of samples in terms of attitude.

SECTION III:

TABLE IV – CORRELATION BETWEEN KNOWLEDGE AND ATTITUDE REGARDING MENTAL ILLNESS AMONG TEACHERS.

S.NO.	VARIABLES	STATISTICAL RESULTS
1.	Knowledge and Attitude	r = .957**

Table IV indicates that, there is a positive correlation between knowledge and attitude **(r =.957).** It implies that, the higher the knowledge, the more favorable attitude. There is a significant relationship between the knowledge and attitude. The research hypothesis accepted.

SECTION IV:

TABLE V – ASSOCIATION BETWEEN THE KNOWLEDGE AND DEMOGRAPHIC VARIABLES:

S. NO.	DEMOGRAPHIC VARIABLES	KNOWLEDGE						Chi-Square
		LOW		MEDIUM		HIGH		
		F	%	F	%	F	%	
1.	**AGE:**							
	1) Below 30 years	11	18.3	4	6.7	0	0	
	2) 31 – 40 years	3	5	31	51.7	0	0	49.146**
	3) 41 – 50 years	1	1.7	5	8.3	2	3.3	
	4) 50 years and above.	1	1.7	0	0	2	3.3	
2.	**GENDER:**							
	1) Male	8	13.3	19	31.7	4	6.7	4.038
	2) Female	8	13.3	21	35.0	0	0	#
3.	**RELIGION:**							
	1) Hindu	11	18.3	31	51.7	4	6.7	1.793
	2) Christian	5	8.3	9	15	0	0	#
4.	**MARITAL STATUS:**							
	1) Unmarried	3	5	7	11.7	0	0	1.404
	2) Married	13	21.7	32	53.3	4	6.7	#
	3) Widow	0	0	1	1.7	0	0	
5.	**EDUCATIONAL STATUS**:							
	1) Undergraduate	12	20.0	6	10.0	0	0	
	2) Postgraduate	4	6.7	34	56.7	4	6.7	21.429**
6.	**LOCALITY:**							
	1) Rural	14	23.3	11	18.3	0	0	
	2) Urban	2	3.3	29	48.3	4	6.7	19.989**
7.	**PLACE OF WORK:**							
	1) Private School	10	16.7	28	46.7	4	6.7	2.143
	2) Government school	6	10.0	12	20.0	0	0	#
8.	**PREVIOUS EXPERIENCE:**							
	1) Yes	2	3.3	21	35.0	3	5.0	9.197**
	2) No	14	23.3	19	31.7	1	1.7	
9.	**FAMILY HISTORY:**							
	1. Yes	0	0	1	1.7	0	0	.508
	2. No	16	26.7	39	65.0	4	6.7	#

NOTE: ** Indicates highly significant.

# Indicates not significant.

Table V shows that, there is a significant association between knowledge of teachers toward mental illness and demographic variables such as age, education, locality, previous experience at the level of $p<0.01$. The above findings support the research hypothesis.

Unexpectedly, there is no consistent association observed between the knowledge and demographic variables such as gender, religion, marital status, place of work, family history at the level of $p>0.05$. The above findings fail to support the research hypothesis so the researcher accepts the null hypothesis.

SECTION V:

TABLE VI – ASSOCIATION BETWEEN THE ATTITUDE AND DEMOGRAPHIC VARIABLES:

S. NO.	DEMOGRAPHIC VARIABLES	ATTITUDE						Chi-Square
		LOW		MEDIUM		HIGH		
		F	%	F	%	F	%	
1.	**AGE:**							
	1. Below 30 years	7	11.7	7	11.7	1	1.7	24.122**
	2. 31 – 40 years	2	3.3	28	46.7	4	6.7	
	3. 41 – 50 years	0	0	5	8.3	3	5.0	
	4. 50 years and above.	0	0	1	1.7	2	3.3	
2.	**GENDER:**							
	1. Male	5	8.3	19	31.7	7	11.7	1.866 #
	2. Female	4	6.7	22	36.7	3	5.0	
3.	**RELIGION:**							
	1. Hindu	6	10.0	32	53.3	8	13.3	.609 #
	2. Christian	3	5.0	9	15.0	2	3.3	
4.	**MARITAL STATUS:**							
	1. Unmarried	3	5.0	7	11.7	0	0	
	2. Married	6	10.0	34	56.7	9	15.0	8.512 #
	3. Widow	0	0	0	0	1	1.7	
5.	**EDUCATIONAL STATUS:**							
	1. Undergraduate	9	15.0	8	13.3	1	1.7	25.052**
	2. Postgraduate	0	0	33	55.0	9	15.0	

6.	**LOCALITY:** 1. Rural 2. Urban	9 0	15.0 0	15 26	25 43.3	1 9	1.7 15.0	17.161**
7.	**PLACE OF WORK:** 1. Private school 2. Government school	8 1	13.3 1.7	25 16	41.7 26.7	9 1	15.0 1.7	5.024 #
8.	**PREVIOUS EXPERIENCE:** 1. Yes 2. No	0 9	0 15.0	18 23	30.0 38.3	8 2	13.3 3.3	12.363**
9.	**FAMILY HISTORY:** 1. Yes 2. No	0 9	0 15.0	1 40	1.7 66.7	0 10	0 16.7	.471 #

NOTE: ** Indicates highly significant.
# Indicates not significant.

Table VI shows the association between demographic variables and attitude of teachers regarding mental illness. Significant association found in age, education, locality, and previous experience at the level of $p>0.01$. The above findings support the research hypothesis.

There were also inconsistent association between the attitude and demographic variables such as gender, religion, marital status, place of work, family history at the level of $p<0.05$. The above findings fail to support the research hypothesis so the investigator accepted the null hypothesis.

CHAPTER V
DISCUSSION

The aim of the research was to identify the knowledge and attitude towards mental illness among teachers. The study was descriptive in nature. A total of 60 teachers participated. A quantitative approach was used for the present study. A convenient sampling technique was used to select the samples. The data collection tools used were demographic profile, semi structured knowledge questionnaire and modified form of orientation towards mental illness scale **(PRABHU 1983).** The content validity and reliability was obtained for the entire tool. The pilot study was done on 6 teachers who met the sampling criteria**.**

The findings of the study have been discussed in terms of objectives and hypothesis stated for the study.

The first objective was to identify the level of knowledge of teachers towards mental illness.

In this study analysis shows that majority of the subjects 40(66.7%) had moderately adequate knowledge, 16(26.7%) had inadequate knowledge and 4(6.7%) had adequate knowledge.

The present study was supported by the study conducted in the University of Ibadan, Nigeria (2006). Erroneous beliefs about causation and lack of adequate knowledge have been found to sustain deep – seated negative attitudes about mental illness. Conversely, better knowledge is often reported to result in improved attitudes towards people with mental illness. A belief that mental illnesses are treatable can encourage early treatment seeking and promote better outcomes. Thus, one can speculate that improved knowledge about causation may lead to improved overall knowledge about mental illness and promote a more tolerant attitude to the mentally ill.

In conclusion, this study marks that poor knowledge about the cause and nature of mental illness is common in the community. It is indicated among 60 teachers that only 16(26.7%) had adequate knowledge towards mental illness.

Even though there are many steps taken by the Indian Government to treat and rehabilitate the mentally ill, stigma continue to persist and it's still a barrier for people with mental illness.

In a survey intended to examine changes in public beliefs about social and environmental variables as risk factors for mental disorders in Australia and Japan over an 8 year period.

Also, the Nigerian study reports that knowledge of mental illness was generally poor. Consistent with the generally poor knowledge, attitudes to the mentally ill were predominantly negative.

At the time of interview few teachers had shown interest to know about mental illness. Others were keen on answering the questions asked but none of them was clear about mental illness. The government motto is to integrating public into the care of people with mental illness.

The second objective of the study was to identify the attitudes of teachers towards mental illness.

The data analysis shows that 41(68.3%) had favorable attitude towards mental illness, 10(16.7%) had most favorable attitude and 9(15%) had unfavorable attitude towards mental illness.

The study statement tends to accept the World Mental Health Day (WMHD) which falls on October 10th 2009, was created to educate and spread vital information about mental health and forms of mental illnesses; the

objectives of WMHD also seek to dispel myths and misconception, and to remove the stigma surrounding mental illnesses. “Mental Health in Primary Care: Enhancing Treatment and Promoting Mental health” forms the themes of World Mental Health Day 2009.

The objectives seek to recognize the need to integrate mental healthcare into mainstream healthcare to ensure universal access. This assumes all the more importance in the light of the recent prediction made by the World Health Organization, that in the next two decades, Depression is likely to be the number one illness affecting millions of people worldwide. Mental illness is just like any other illness – it needs medical care and support, not stigma.

The literate people like teachers are not much aware of mental illness and its nature. For instance, the attitude scale has a question that if every mental hospital must be surrounded by high fence and walls, for which most of the respondents agreed and a few even strongly agreed. This scenario indicates people do not dare to understand and care.

Contrary to expectation, this study shows negative attitudes towards mental illness to be highly prevalent across many different groups in the community.

The third objective was to find out knowledge and attitude of teachers towards mental illness.

The subsequent hypothesis was there will be a significant relationship between knowledge and attitude of teachers towards mental illness.

The study analysis marks that, there is a positive relationship between knowledge and attitude **(r =.957)** It implies that, the higher the knowledge, more the favorable attitude.

The recent study supported by the report of Stigma in developing countries – Srilanka revels that, stigmatizing attitudes may be encountered even amongst educated groups of people. Stigmatization of the mentally ill is still a very pertinent issue that has to be addressed worldwide and more community based research needs to be done. Also poor knowledge about mental illness seemed to pervade all segments of the community.

The fourth objective was to find out the association between the knowledge of teachers towards mental illness with demographic variables such as age, gender, education, religion, marital status, previous experience, family history of mental illness.

The corresponding hypothesis was there will be a significant association between knowledge of teachers with selected demographic variables such as age, gender, education, locality, previous experience with mentally ill patients.

There is a significant association between knowledge of teachers toward mental illness and demographic variables such as age, education, locality, previous experience at the level of $p<0.01$.

Unexpectedly, no consistent association was observed between the knowledge and demographic variables such as gender, religion, marital status, place of work, family history at the level of $p>0.05$.

More recent research supports this objective. People with mental illness are seen as ‘different’ - hard to talk with, and unpredictable. Gender makes no difference to attitudes, nor does personal contact leads to more tolerant attitudes.

The fifth objective was to find out the association between attitude of teachers towards mental illness demographic variables such as age, gender, education, locality, previous experience with mentally ill patients.

The corresponding hypothesis was there will be a significant association between attitude of teachers towards mental illness with selected demographic variables such as age, education, locality, previous experience with mentally ill patients.

There was a significant association between demographic variables with attitude of teachers regarding mental illness, such as age, education, locality, and previous experience at the level of $p>0.01$.

There were also inconsistent association between the attitude and demographic variables such as gender, religion, marital status, place of work, family history at the level of $p<0.05$.

This current study is supported by, Shusrut Jadhav et al's (2007) study on Stigmatization of severe mental illness in India. This study shows greater stigma and a punitive attitude among rural Indians as compared to urban Indians. It also represents Urban Indians reported a more liberal and tolerant attitude but were also more excluding of those with mental illness at work.

This small scale project is the reflection of public knowledge and attitude towards mental illness. Dr. Narendranath Wig is an eminent Psychiatrist from Chandigarh. He highlights that, the first step in promoting mental health is to encourage awareness among public about the importance of mental health in life. Secondly, stigma and prejudice associated with mental disorders should be reduced.

The status of mental health is not very encouraging in India. Primarily because of stigma attached to the problem. To get more people to access mental health care there is urgent need for education and information about mental health problems.

CHAPTER VI

SUMMARY, FINDINGS, IMPLICATIONS, RECOMMENDATIONS, AND CONCLUSION

The aim of the study was to investigate the knowledge and attitude of the school teachers towards mental illness, specifically causes of mental illness, treatment and misconceptions.

The study design was discriptive. Semi structured knowledge questionnaire and modified form of attitude scale were used with a group of teachers. After assessing the knowledge a self instructional module was set to create awareness about mental illness. The data was grouped and analyzed using descriptive statistics and inferential statistics.

OBJECTIVES OF THE STUDY:

The objectives of the study were;

1. To identify the knowledge of teachers towards mentally illness.
2. To identify the attitudes of teachers towards mental illness.
3. To find out the relationship between knowledge and attitude of teachers towards mental illness.
4. To find out the association between the knowledge of teachers towards mental illness with demographic variables such as age, gender, education, locality and previous experience with mentally ill patients.
5. To find out the association between attitude of teachers towards mental illness demographic variables such as age, gender, education, locality and previous experience with mentally ill patients.

HYPOTHESIS:

The level of significance chosen for all the hypothesis was 0.05 level and samples selected for the study purpose were teachers those are working in higher secondary schools.

H1: There will be a significant relationship between knowledge and attitude of teachers towards mental illness.

H2: There will be a significant association between knowledge of teachers with selected demographic variables such as age, gender, education, locality, previous experience with mentally ill patients.

H3: There will be a significant association between attitude of teachers towards mental illness with selected demographic variables such as age, education, locality, previous experience with mentally ill patients.

Conceptual framework used for the study was based on Health Belief Model of Rosenstock (1974). A quantitative approach was used for the present study. The study population comprised of teachers working in Sivagangai District. A convenient sampling technique was used to select samples. The data collection tools used were demographic profile, self administered knowledge questionnaire, and modified form of attitude scale. The content validity and reliability was obtained for the entire tool. The pilot study was done on 6 teachers who met the sampling criteria.

Analysis of the data was done on the basis of the objectives. The descriptive and inferential statistics (SPSS) were used to analyze the data.

MAJOR FINDINGS:

- Considerable number of teachers 15(25%) were below 30 years, 34(56.7%) teachers were between 31- 40 years, 3(5%) fell in the category of 50 years and above.

- The gender distribution shows that the male participants were 31(51.7%), and female were 29(48.3%).

- The great majority of teachers were Hindus 46(76.7%), 14(23.3%) were Christians.

- The percentage of unmarried teachers was 10(16.7%), married 49(81.7%) and widow 1(1.7%).

- With regard to educational status of teachers 18(30%) were undergraduates and 42(70%) were postgraduates.

- Considering the residence of teachers, 25(41.7%) were from to rural area and 35(58.3%) were from urban area.

- Place of work reveals 42(70%) teachers were from private school and 18(30%) were from Government school.

- Regarding the previous experience of teachers 34(56.7%) had no experience 26(43.3%) had known someone with mental illness.

- Majority 59(98.3%) had no family history of mental illness. One (1.7%) had family history of mental illness.

- Majority of the subjects 40(66.7%) had moderately adequate knowledge, 16(26.7%) had inadequate knowledge and 4(6.7%) had adequate knowledge.

- In case of attitude 10(16.7%) had most favorable attitude towards mental illness, 41(68.3%) had favorable attitude and 9(15%) had unfavorable attitude towards mental illness.

- There is a positive correlation between knowledge and attitude **(r =.957).** It implies that, higher the knowledge, the more the favorable attitude.

- There was a significant association between knowledge of teachers toward mental illness and demographic variables such as age, education, locality, previous experience at the level of $p<0.01$.

- There was an association between demographic variables and attitude of teachers regarding mental illness. Significant association found in age, education, locality, and previous experience at the level of $p<0.01$.

IMPLICATIONS TO NURSING PRACTICE:

Nursing practice is moving towards multiple care settings that are based in institutions, community and home care. Psychiatric nursing is a specialized area of nursing practice employing theories of human behavior as its scientific aspect and purposeful use of self as its art. It is directed toward both preventive and corrective impacts upon mental illness and is concerned with the promotion of optimum health for society.

NURSING EDUCATION:

The present study has implication on nursing education. Discrimination against and the stigma of people with experience of mental illness is widespread

(Sayce 1998; Crisp, Gender et al 2000). Discrimination occurs when a person is treated differently from another person in similar circumstances. Therefore nurses have to educate the public psychological underpinnings of psychiatric disorders and about the value of human beings. A better understanding of these disorders amongst the public would presumably lessen the stigmatization and encourage the use of currently available and effective interventions.

NURSING ADMINISTRATION:

The findings of the study can help the administrators in preparing nurses for counseling and teaching the public about mental illness and its management. Policies can be made where the nurse plays an important role in raising awareness, reinforce positive attitudes towards mental illness.

NURSING RESEARCH:

Attitude research in psychiatry made considerable progress over the past 15 years in developed countries. However, it is our culture and in our institutions that the stigmatism of mental illness continues to persist. Continuing research increase the general knowledge of the community with regard to mental illness with the hope that their attitudes to the mentally ill can be improved.

RECOMMENDATIONS:

- A similar study can be done in a large sample for the purpose of generalization.
- A comparative study can be done with two groups.
- A study can be done in urban and rural setting and results can be compared.
- A similar study can be carried out and anti – stigma educational programs and campaigns may be conducted.
- A similar study can be conducted by the use of different attitude scales.

CONCLUSION

In India 15million people are battling serious mental health problems. Nearly 50% of victims suffering serious mental health disorders go untreated. The fortunate part is that most mental illnesses can be successfully treated. The Government of India also has taken special interest in mental health care in the form of National Mental Health Programme. Stigma is one of the major difficulties faced by people with mental illness, due to which they hesitate seeking help. The mental health services are not utilized by the beneficiaries properly. Many of them suffer alone silently. By accident, we are all responsible for this situation. The researcher strongly believes that appropriate information of the mentally ill to the public and positive attitude would brings great changes in the life of the mentally ill.

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INTERNET RESOURCES:

- www.goole.com
- www.yahoo.com
- www.pubmed.com
- www.mentalhealth.com
- www.mentalhelp.net
- www.medline.com
- www.psychiatricnursing.com

APPENDIX IV

PART – I DEMOGRAPHIC DATA

INSTRUCTIONS TO TEACHERS:

Read carefully, and give appropriate response in each column.

1. Age
   a. Less than 30 years [ ]
   b. 31-40 years [ ]
   c. 41-50 years [ ]
   d. 50 years and above [ ]
2. Gender
   a. Male [ ]
   b. Female [ ]
3. Religion
   a. Hindu [ ]
   b. Muslim [ ]
   c. Christian [ ]
   d. Others [ ]
4. Marital status
   a. Single [ ]
   b. Married [ ]
   c. Divorced [ ]
   d. Widow [ ]
5. Education
   a. Undergraduate [ ]
   b. Postgraduate [ ]
6. Locality [ ]
   a. Rural [ ]
   b. Urban
7. Place of work
   a. Government school [ ]
   b. Private school [ ]
8. Do you have any previous exposure with mentally ill patient
   Yes / No
9. Do you have any family member suffering with mental illness
   Yes / No

APPENDIX V
PART – I
KNOWLEDGE QUESTIONNAIRE

Read the following statements carefully. If you feel the statement is correct put a tic mark. If you feel the statements are incorrect put an (x) mark in the bracket.

S.NO.	KNOWLEDGE QUESTIONNAIRE	YES	NO
1.	Mental health and physical health are like two of the coin sides.		
2.	Mental illness is hereditary.		
3.	Anybody under stress can become mentally ill.		
4.	By coming and contact with or living with mentally ill, on mentally ill.		
5.	Only poor people suffer from mental illness.		
6.	Excess heat can cause severe mental illness.		
7.	It is safe to keep mentally ill persons inside the mental hos		
8.	A treated mentally ill person can work with responsibility		
9.	In addition to drugs, mental patients need love and encour		
10.	Mental illness can be treated in local hospital.		
11.	Once the drugs are prescribed patients need not consult th again.		

S.NO.	KNOWLEDGE QUESTIONNAIRE	YES	NO
12.	Government Rajaji Hospital facilitates the treatment for mentally ill.		
13.	There is a government mental hospital is located at ayyanavaram Tamilnadu.		
14.	Alcohol and drug abuse also treatable in psychiatric unit.		
15.	Beating and locking the patient in a room is violation against human rights.		
16.	If a person feels that he needs a psychiatric aid he/she can admitted by self.		
17.	The person with unsound mind cannot give will/ witness.		
18.	Erwadi tragedy awakens the law makers of our country.		
19.	Medias portray mentally ill in a negative fashion.		
20.	There are rehabilitation centers for chronic and destitute people.		

APPENDIX VI

PART III

ATTITUDE SCALE

ORIENTATION TOWARDS MENTAL ILLNESS SCALE (PRABHU 1983) MODIFIED FORM:

On the following pages you will find a number of statements about mental health problems. I want to know how much you agree or disagree with each statements. To the right of each statement you will find a scale.

Disagree Agree
1 2 3 4 5

The points along the scale (1, 2, 3, 4 and 5) can be interpreted as follows.

1) Completely or strongly disagree
2) Disagree
3) Cannot say or do not know.
4) Agree
5) Completely or strongly agree

If you agree completely with a statement, than circle the number '5' that is there on the right of the statement (but not completely disagree). Then place the circle around the number '2' in the scale. In this way you can indicate whether you agree or disagree with each of the statement on the following pages.

Like everyone else, you will probably feel that you cannot give an answer to some of the statement. When that occurs make the guess that you can.

S.No.	**Orientation scale**	Strongly Disagree 1	Disagree 2	No Opinion 3	Agree 4	Disagree 5
1	The cause of mental illness is divine displeasure.					
2	After an attack of mental illness, these individual become very antisocial.					
3	Practice of yoga prevents mental illness.					
4	After an attack of a mental illness the patients loss a lot of weight.					
5	Patients who had been a mental hospital will never be their old selves again.					
6	Mentally ill individual are not at all trust worthy.					
7	To treat mental patient effectively, it costs too much money.					
8	Taking mentally ill to holy places cures them.					
9	Unmarried persons are less likely to develop mental illness than married persons.					
10	Mental patients commit lot of crimes.					
11	Those that have lost the parents during childhood have a greater risk of developing mental illness.					
12	People look much older after they recover from mental illness.					
13	Every mental hospital must be surrounded by high fence and walls.					
14	Mentally ill persons are dangerous to those around them.					
15	Fasting cures mental illness.					
16	The sexual habits of mentally ill persons are very perverse.					
S.No.	**Orientation scale**	Strongly Disagree 1	Disagree 2	No Opinion 3	Agree 4	Disagree 5
17	Regardless of have you look at it,					

	patients with mental illness are no longer really human.					
18	Religious ceremonies help the patients to come out of mental illness.					
19	To treat a mental patient, the most important thing is to teach him how to control his emotions.					
20	Ayurvedic medicines are very effective in treating the mentally ill.					
21	Mental illness is due to damaged or diseased brain.					
22	People become mentally ill when they come under the influence of evil stars.					
23	Mental illness is caused by the influence of the moon.					
24	Brain operation alone can cure mental illness.					
25	Electric shock therapy is the only effective method of treatment available to treat the mentally ill persons.					
26	Mentally ill persons are incapable of taking even minor decisions.					
27	A person who had mental illness cannot be a good partner.					
28	Mental hospital must be situated far away from the city.					
29	Saliva usually dribbles from the mouth of mentally ill persons.					
30	If a person is dominated by others, he is likely to develop mental illness.					

APPENDIX II

MATHA COLLEGE OF NURSING

VAANPURAM, MANAMADURAI, SIVAGANGAI Dt-630606

LETTER SEEKING PERMISSION TO CONDUCT STUDY IN SIVAGANGAI DISTRICT.

To

The Head Master,
O.V.C. Higher Secondary School,
Manamadurai.

Respected Sir/Madam,

Sub: Project work of M.Sc (Nursing) student at selected schools in Manamadurai

I am to state that Ms.Gnanaguruvammal.G is a final year M.Sc., Nursing student has to conduct a project, which is to be a partial fulfillment of university requirement for the degree of Master of Science in Nursing.

The topic of research is **"A study to assess the knowledge, attitude towards mental illness among school teachers at Sivagangai District.**

Kindly permit her to do the research work in your esteemed institution under your valuable guidance and suggestion.

Thanking you.

Prof. JEBAMANI AUGUSTINE, M.SC. (N)
PRINCIPAL

APPENDIX I
LETTER SEEKING EXPERT'S OPINION FOR CONTENT VALIDITY

From

MS.Gnanaguruvammal.G
M.Sc., Nursing II year
Matha College of Nursing,
Manamadurai,

To

Respected sir/madam,

Sub:

Requesting opinion and suggestion of experts for content validity of **"A study to assess the knowledge, attitude towards mental illness among school teachers at Sivagangai District.**

I request you to kindly validate the tool and give your opinion for necessary modification and also I would be very great full, if you could refine the problem statement and the objectives.

ENCLOSURES:

- Statement of the problem
- Objectives
- Hypothesis
- Research tool

Thanking you.

APPENDIX III

LIST OF EXPERTS CONSULTED FOR THE CONTENT VALIDITY OF RESEARCH TOOL:

1. **Prof. JEBAMANI AUGUSTINE M.SC. (N),**
   Principal,
   Matha College of Nursing,
   Manamadurai.

2. **Dr. ARUN,**
   Senior Resident,
   Department of Psychiatry,
   NIMHANS

3. **Dr. K. REDDAMMA, Ph.D,**
   Professor and Head,
   Department of Nursing,
   NIMHANS
   Bangalore.

4. **Dr**. **RAMACHANDRA,**
   Assistant professor,
   Department of nursing,
   NIMHANS
   Bangalore.

5. **Dr. NAGARAJAIAH,**
   Associate professor,
   Department of nursing,
   NIMHANS
   Bangalore.

6. **Dr. JAMUNA,**
   Assistant professor,
   Department of mental health & social psychology,
   NIMHANS
   Bangalore.

7. **Mr. RADHA KRISHNAN, M.sc.(N)**
   Principal,
   Bharatesh College of nursing,
   Belgam

APPENDIX VIII
SELF INSTRUCTIONAL MODULE ON KNOWLEDGE AND ATTITUDE TOWARDS MENTAL ILLNESS SOME FACTS ABOUT MENTAL ILLNESS:

Good Morning,

Dear Teachers...

Indian Government has taken imperative steps to promote mental health and to prevent mental illness. Practically mental health services are not utilized by the beneficiaries properly. The reason behind is improper information and negative attitude towards mentally ill. Partnership of local members and appropriate information helps in the promotion of mental health and prevention of mental disorders in the society.

CAUSES OF MENTAL ILLNESS:

MODIFIABLE FACTORS:

1. Excessive stress
2. Loneliness
3. Divorce
4. Frustration
5. Unemployment
6. Urbanization

NON MODIFIABLE FACTORS:

1. Hereditary
2. Those have lost the parents during childhood.
3. Childhood insecurities.

4. Changes in the brain chemicals.

5. Personalities.

ESSENTIAL INFORMATION RELATE TO MENTAL ILLNESS:

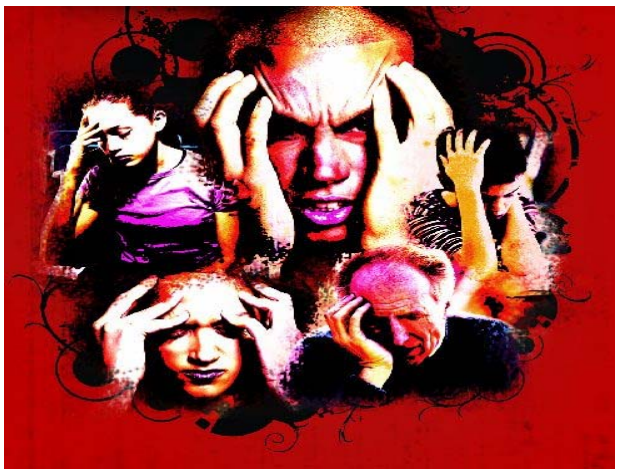
- There is a government mental hospital is located at ayyanavaram tamilnadu.
- Government Rajaji hospital at Madurai facilitates the treatment for mentally ill.

Alcohol and drug abuse also treatable in psychiatric unit.

- Beating and locking the patient in a room is violation against human rights.
- If a person feels that he needs a psychiatric aid he or she can admitted by self. This is called as voluntary admission. It is also encouraged by psychiatric team.
- According to Indian constitution the person with unsound mind cannot give will/ witness.
- The practice of yoga is not only for physical health, also necessary for mental health.
- We must regard as mentally ill also human beings.
- Additional to electric shock therapy numerous treatment modalities are also available.

MYTHS AND MISCONCEPTIONS ABOUT MENTAL ILLNESS:

- Mental illness is caused by supernatural power or evil spirit or curse.



- After an attack of mental illness, these individuals become very antisocial.
- To treat mental patient effectively, it costs too much money.
- Mental hospitals must be surrounded by high fence and walls.
- Fasting cures mental illness.

- ❖ Brain operation alone can cure mental illness.
- ❖ Saliva usually dribbles from the mouth of mentally ill persons.
- ❖ Mental patients commit lot of crimes.
- ❖ They are dangerous to those around them.

As a community member, we need to arm ourselves with information concerning mental illness in order to assist the massive ill population in all corners of the country. Societies have to remove the taboo status from mental illness and learn acceptance and tolerance. The literate people like teachers must assist mentally ill people to seek professional solutions as necessary.

This fraction of information may play a pivotal role in the life of a mentally ill in our society.

THANK YOU.